the physician and must be authorized by the Medicaid Program prior to purchase of the drug.

iv. Oxygen and related equipment is covered when the medical need is discovered during a screening service and is physician ordered. PRN oxygen or oxygen as needed on less than a continual basis will be authorized for six (6) months following receipt of medical documentation from the attending physician as to an acute or chronic medical condition which requires oxygen support to maintain respiratory status. Medical documentation will include a diagnosis, oxygen flow rate and concentration, and an estimate of the frequency and duration of use. Portable oxygen systems my be ordered to compliment a stationary system if the recipient is respirator dependent, or the attending physician documents the need for a portable oxygen system for use in transportation. Laboratory evidence for hypoxemia is not required.

v. Respiratory Care Services: are not currently provided under the Idaho State Plan but are made available to EPSDT recipients.

vi. The following State Plan limitations will not apply to any eligible Medicaid child being served in Idaho under the EPSDT program.
Idaho's list of services which are not currently provided or are limited under the Idaho State Plan, but are available to EPSDT recipients if discovered by the screening service and are found to be medically necessary.
All services outside the Idaho State Plan will require prior authorization by the Department.

a. OUT-PATIENT HOSPITAL SERVICES: Limit of six (6) emergency room visits will be waived for EPSDT recipients.
b. PHYSICIAN SERVICES: Limit of twelve (12) hours of psychiatric evaluations and maximum of forty-five (45) hours of psychotherapy in any twelve (12) month period will be waived for EPSDT recipients.
c. HOME HEALTH SERVICES: Limit of one-hundred (100) visits per calendar year will be waived for EPSDT recipients.
d. PHYSICAL THERAPY SERVICES: Limit of one-hundred (100) visits of out-patient physical therapy per calendar year will be waived for EPSDT recipients.
e. REHABILITATIVE SERVICES – DEVELOPMENTAL DISABILITIES AGENCIES: Limit of twelve (12) hours reimbursable time allowed for the combination of all

Evaluations or diagnostic services; limit of two-hundred (200) treatment sessions per calendar year of speech and hearing therapy; limit of maximum of thirty (30) hours per week of developmental and occupational therapy will be waived for EPSDT recipients.

f. CLINICAL SERVICES – MENTAL HEALTH CLINICS: Limit of twelve (12) hours maximum for a combination of any evaluative or diagnostic services per calendar year; limit of fifty-six (56a) hours per week of partial treatment will be waived for EPSDT recipients.

g. CLINIC SERVICES – DIAGNOSTIC SCREENING CLINICS: Limit of no more than five (5) hours of medical social services per recipient in each state fiscal year will be waived for EPSDT recipients.

h. PERSONAL CARE SERVICES – UNDER EPSDT: Must be in excess of sixteen hours of service per week.

i. PROSTHETIC AND ORTHOTIC SERVICES: Limit of one refitting, repair or additional parts in a calendar year will be waived for EPSDT recipients.

j. CASE MANAGEMENT SERVICES: See Supplement to attachment 3.1A.

k. SINGLE OR DOUBLE LUND, AND COMBINED HEART-LUNG TRANSPLANTS. Exclusion of single lung, double lung, and heart/lung transplants will be waived for EPSDT patients. All other requirements regarding the pre-authorization of hospital stays and use of Medicare certified transplants facilities will continue to apply.

SUPPLEMENT 1TO ATTACHMENT 3.1A4.b.vi.j

CASE MANAGEMENT SERVICES

A) Target Group: Medicaid eligible children age birth to twenty-one (21) years of age who meet the medical necessity criteria.

Medical Necessity Criteria.
Medical necessity criteria for SC services under EPSDT are as follows: Children eligible for SC must meet one of the following diagnostic criteria: Children who are diagnosed with a physical or mental condition which has a high probability of resulting in developmental delay or disability, or children with developmental delay or disability. Developmentally delayed children are children with or without established conditions who by assessment measurements have fallen significantly behind developmental norms in one or more of the five functional areas which include cognitive development; physical development including vision and hearing; communication; social/emotional development; and adaptive skills. Children who have special health care needs requiring medical and multidisciplinary habilitation or rehabilitation services to prevent or minimize disability. Special health care needs may include a wide range of physical, mental, or emotional limitations from birth defects, illness, or injuries. Children who have been diagnosed with a severe emotional/behavioral disorder under DSM-IV or subsequent revisions or another classification system used by the Department; and expected duration of the condition is at least one (1) year or more. Children eligible for SC must have one (1) or more of the following problems associated with their diagnosis: The condition requires multiple services providers and treatments; or the condition has resulted in a level of functioning below age norm in one (1) or more life areas, such as school, family, or community; or there is risk of out-of-home placement or the child is returning from an out-of-home placement as a result of the condition; or there is imminent danger to the safety or ability to meet basic needs of the child as a result of the condition; or further complications may occur as a result of the condition without provision of services coordination services; and the family needs a service coordinator to assist them to access medical and other services for the child.

B) Areas of the State Which Services Will Be Provided:

[X] Entire State

[ ] Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than statewide.

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C) Comparability of Services

[ ] Services are provided in accordance with section 1902(a)(10)(B) of the Act.

[XX] Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D) Description of Service.
SC services shall be delivered by eligible providers to assist the Medicaid child and their family to obtain and coordinate needed health, educational, early intervention, advocacy, and social services identified in an authorized SC plan developed by the Department or their contractor. Services must take place in the least restrictive, most appropriate and most cost effective setting. SC services shall consist of the following core functions: Coordination/Advocacy, which is the process of facilitating the child's access to the services, evaluations, and resources identified in the service plan. The case manager may advocate on behalf of the child and family for appropriate community resources and coordinate the multiple providers of social and health services defined in the service plan to avoid the duplication of services for the child. Monitoring, which is the ongoing process of ensuring that the child's service plan is implemented and assessing the child's progress toward meeting the goals outlined in the service plan and the family's satisfaction with the services. Direct in-person contact with the child and the child's family is essential to the monitoring process. Evaluation, which is the process of determining whether outcomes have been reached on the service plan, the need for additional revised outcomes, the need for a new plan, or if services are no longer needed. Evaluation is accomplished through periodic in-person reassessment of the child, consultation with the child's family, and consultation and updated assessment from other providers. The addition of new services to the plan or increase in the amount of an authorized service on the existing plan must be authorized by the Department prior to implementation. Crisis Assistance, which are those SC activities that are needed in emergency situations in addition to those identified on the service plan. These are necessary activities to obtain needed services to ensure the health or safety of the child. To the extent possible the plan should include instructions for families to access emergency services in the event of a crisis. If a need for twenty-four (24) hour availability of service coordination is identified, then arrangements will be made and included on the plan. Encouragement of Independence, which is the demonstration to the child, parents, family, or legal guardian of how to best access service delivery systems.

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E) Qualifications of Providers.
SC provider agencies must have a valid provider agreement with the Department and meet the following criteria: Demonstrated experience and competency in providing all core elements of service coordination services to children meeting the medical necessity criteria. Level of knowledge sufficient to assure compliance with regulatory requirements. Adherence to provision of provider agreement for EPSDT service coordination. Provider agreement may include, but is not limited to, requirements for training, quality assurance, and personnel qualifications.

Service Coordination Individual Provider Staff Qualifications. All individual SC providers must be employees of an organized provider agency that has a valid SC provider agreement with the Department. The employing entity will supervise the individual SC providers and assure that the following qualifications are met for each individual SC provider: Must be a licensed M.D., D.O., social worker, R.N., or have at least a B.A./B.S. in human/health services field; and have at least one (1) year's experience working with children meeting the medical necessity criteria. Individuals without the one (1) year experience may gain this experience by working for one (1) year under the supervision of an individual who meets the above criteria. Paraprofessionals, under the supervision of a qualified SC, may be used to assist in the implementation of the service plan. Paraprofessionals must meet the following qualifications: be eighteen (18) years of age and have a high school diploma or the equivalent (G.E.D.); be able to read at a level commensurate with the general flow of paperwork and forms; meet the employment standards and required competencies of the provider agency; and meet the training requirements according to the agency provider agreement. Pass a criminal history background check. The caseload of service coordinators will be limited to fifty (50) when using one (1) or more paraprofessionals to implement the plan. If not using paraprofessionals, the individual service coordinator's caseload shall not exceed thirty-five (35). At no time will the total caseload of a service coordinator be so large as to violate the purpose of the program or adversely affect the health and welfare of any children served by the service coordinator. A waiver to the caseload limit may be granted by the Department on a case by case basis and must meet the following criteria: The availability of service coordinators is not sufficient to meet the needs of the service area; or the recipient's family who has chosen the particular service coordinator who has reached his limit, has just cause to need that particular provider over other available providers; or the individual service coordinator's caseload consists of twenty-five percent (25%) or more maintenance level (two (2) hours per month or less of service coordination services) recipients; and the request for waiver must include: The time period for which the waiver is requested; and the alternative caseload limit requested; and documentation that the granting of the waiver would not diminish the effectiveness of the service coordinator's services, violate the purposes of the program, or adversely affect the health and safety of any of the service coordinator's consumers. The Department may impose any conditions, including limiting the duration of a

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waiver, which they deem necessary to ensure the quality of the service coordination services provided.

F) The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Sec. 1902(a)(23) of the Act.
   1) Eligible recipients will have free choice of the providers of case management services.
   2) Eligible recipients will have free choice of the providers of other medical care under the plan.

G) Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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4. c. Family Planning Services and Supplies for persons of child bearing age:
The Department will provide Family planning services which includes; counseling and medical services prescribed by a licensed physician,qualified certified nurse practitioner, or physician's assistant. The Department will cover diagnosis, treatment, contraceptive supplies, related counseling, and restricted sterilization.

Contraceptive supplies include condoms, foams, creams and jellies, prescription diaphragms, intrauterine devices, or oral contraceptives are limited to a three month supply.

Sterilization procedures are limited to persons who are at least 21 years of age or older at the time of signing the informed consent form. A person over the age of 21 that is incapable of giving informed consent will be ineligible to receive medicaid payment for the sterilization. The person must voluntarily sign the informed consent form at least 30 days, but not more than 180 days prior to the sterilization procedure. Sterilizations for individuals institutionalized in correctional facilities, mental hospitals, or other rehabilitative facilities are ineligible unless ordered by the court of law. Hysterectomies performed solely for sterilization are ineligible for medicaid payment.

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5.a. Physician Services: The Department will reimburse for treatment of medical and surgical conditions by doctors of medicine or osteopathy subject to the limitations of practice imposed by state law, and in accordance to the restrictions and exclusions of coverage contained in Idaho Department of Health and Welfare Rules and Regulations Sections 03.9065 and 03.9070.02, and listed below.

Excluded Services: Elective medical and surgical treatments, except family planning services are excluded from Medicaid payment without prior approval by the Department. New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service and are excluded by the Medicare program are excluded from Medicaid payment. Non-medically necessary cosmetic surgery is excluded from Medicaid payment.

Surgical procedures for the treatment of morbid obesity and panniculectomies may be covered with prior approval by the Department.

Acupuncture services, naturopathic services, bio-feedback therapy, laetrile therapy, and eye exercise therapy are excluded from Medicaid payment.

Procedures, counseling, office exams and testing for the inducement of fertility are excluded from Medicaid payment.

Lung transplants, pancreas transplants, multiple organ transplants, and other transplants considered investigative or experimental procedures under Medicare criteria are excluded from Medicaid payment.

Drugs supplied to patients for self-administration other than those allowed under Idaho Department and Welfare Rules and Regulations Section 03.9126 are excluded from Medicaid payment.

The treatment of complications, consequences or repair of any medical procedure in which the original procedure was excluded from Medicaid, unless the resulting condition is life threatening as determined by the Medicaid Policy section of the Department is excluded from Medicaid payment.

Hysterectomies that are not medically necessary and sterilization procedures for people under twenty-one (21) are excluded from Medicaid payment.

Payment for tonometry is limited to two (2) exams for individuals over the age of forty (40) during any twelve (12) month period (either separately or as part if a vision exam). Individual with a diagnosis of Glaucoma are excluded from this limitation.

Abortion Services: The Department will only fund abortions to save the life of the mother or in cases of rape or incest as determined by the courts. Two licensed physicians must certify in writing that the mother may die if the fetus is carried to term. This certification must contain the name and address of the recipient.

5. b. Medical and Surgical Furnished by a Dentist: The Department will reimburse for treatment of medical and surgical dental conditions by a licensed Dentist subject to the limitations of practice imposed by state law, and according to the restrictions and exclusions of coverage contained in Idaho Department of Health and Welfare Rules and Regulations Section 03.9125 and listed below.

Dentist Limitations: Elective medical and surgical dental services are excluded from Medicaid payment unless prior approved by the Department. All hospitalizations for dental care must be prior approved by the Department. Non medically necessary cosmetic services are excluded from Medicaid payment. Drugs supplied to patients for self-administration other than those allowed under Idaho Department of Health and Welfare Rules and Regulations Section 03.9125 and 03.9126 are excluded from Medicaid payment.

6. a. Podiatrist's Service are limited to treatment of acute foot conditions.

b. Optometrists' Services are limited to providing eye examination and eye glasses as described in section 12. d. Eyeglasses unless the optometrist has been issued and maintains certification under the provisions of Idaho Code to diagnose and treat injury or diseases of the eye. In these circumstances, payment will be made for diagnosis and treatment services.

c. Chiropractic Services are limited for payment to a total of two (2) office visits during any calendar month. The remedial treatment must involve the manipulation of the spine to correct a subluxation condition.

d. Services Under Other Practitioners includes those services provided a physician assistant as defined by state and federal law. This coverage has the same exclusions as listed in Attachment 3.1A Program Description 5a. Physician Services.

6. d. Services under other practitioners include those services provided by nurse practitioners and physician assistants and as defined by state and federal law. This coverage specifically includes pediatric and family nurse practitioner services as required by Section 1905(a)(21) of the Act (added by Section 6405 of OBRA '89).